Occupational/Speech/Language Therapy Services



In Parkland School Division No. 70

*What can the O.T. consultation help with?*

O.T. Service can assist with programming for children who are challenged in their daily school activities, primarily because of difficulties in the following areas:

|  |  |
| --- | --- |
| Self-Care: | * Eating, dressing and toileting |
| Productivity: | * Use of everyday tools and materials in the classroom challenges may include fine motor skills, visual perception, sensory processing) * Managing environments (positioning/seating, accessibility, organization, attention) |

*What can the SLP consultation help with?*

SLP service can assist with programming for children who are challenged in their daily school activities, primarily because of difficulties in the following areas:

|  |  |
| --- | --- |
| Language: | * Use of language (receptive or expressive), comprehension, and listening skills |
| Speech Mechanics: | * Stuttering, Phonological Awareness, Voice |
|  |  |
| Assistive Technology | * Trial and support of Assistive Technology devices to support speech and communication. |

*Which students are eligible for this service?*

Students in Schools from Grades 1-12 with severe or mild/moderate disabilities can be referred for eligibility. Students meeting eligibility are prioritized, based on the severity of their individual needs.

*Referral Process*

The Request for Consultation Services (Occupational/Speech/Language Therapy) should be completed by the School Team and sent to [therapyservices@psd70.ab.ca](mailto:therapyservices@psd70.ab.ca)

Please ensure that the referral is completed in full, and that needs and concerns are stated specifically.

Written consent for OT/SLP consultation and information sharing is required from the parents or guardians prior to the commencement of service.

Referrals and parental permission must be completed for each school year.

Request for Consultation Services



Grade 1-12

Speech/Language Therapy Occupational Therapy

Year: Click here to enter text.

*Please Forward a Copy to* [*therapyservices@psd70.ab.ca*](mailto:therapyservices@psd70.ab.ca)

Student/Family Information

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name: Click here to enter text. | | | |
| Date of Birth: Click here to enter text. | Grade/Program: Click here to enter text. | | |
| Alberta Education Code/Diagnosis: Click here to enter text. | | | |
| Alberta Education Student #: Click here to enter text. | | | |
| Parents/Guardians: Click here to enter text. | | | |
| Address: Click here to enter text. | | | Postal Code: Click here to enter text. |
| Home Phone: Click here to enter text. | | Alternate Phone: Click here to enter text. | |
| Parent/Guardian E-mail: Click here to enter text. | | | |
| Referring School: Click here to enter text. | | | |
| School Phone: Click here to enter text. | | | |
| Teacher: Click here to enter text. | | | |

Reason for Referral (must be completed):

|  |  |
| --- | --- |
| Current Concerns (must be related to functioning at school | |
| Occupational Therapy (OT): | Speech/Language Therapy (SLP): |
| Sensory Processing | Language (Expressive) |
| Positioning in desk/wheelchair/seating | Language (Receptive) |
| Feeding/swallowing | Speech Mechanics |
| Classroom access | Stuttering |
| Self-care (dressing, toileting) | Hearing |
| Visual perception (ECS only) | Phonological Awareness |
| Assistive Technology | Assistive Technology |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Previous interventions tried: Click here to enter text. | |
| Additional Comments: Click here to enter text. | |
| Date of Last OT/SLP Consultation/Therapist Name: Click here to enter text. | |
| Form completed by: Click here to enter text. | |
| Signature: | Date: Click here to enter text. |

|  |
| --- |
| Attach Parental Information/Consent |

|  |  |
| --- | --- |
|  | **PARENTAL CONSENT FOR PROVIDING**  **SERVICES BY PARKLAND SCHOOL DIVISION THERAPISTS AND CONSULTANTS** |

**Student Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Grade**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As discussed with your school based support team, occupational therapy and/or speech language pathology services have been requested for your child through a specialized services team.

**Occupational Therapy:** Focuses on the development of fine motor skills, self-help, and sensory regulation

**Speech and Language Pathology:** Focuses on the development of expressive (what we say), receptive (what we understand) language, phonology (how we produce) of speech sounds, and social use of language

In Parkland School Division this specialized services team provides embedded or direct programming for your child at his/her school. These services may be one or any combination of the following:

1. Identify therapy needs through an evaluation, whether it be informal or formal
2. Recommend intervention strategies (programming)
3. Provide programming support

Embedded therapy (programing within the classroom) is the preferred model; however when it is determined by the therapy staff that the student requires additional support, a therapist or consultant may provide services to your child.

If you have any questions about this process, please contact your school based support team.

Please return this completed form to your school based support team/classroom teacher. **Your written consent is valid until September 30th, 2013 and may be withdrawn at any time.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_being the parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name) (name of child)

give my consent for the following services to be provided for my child by Parkland School Division:

Please initial which services for which you are providing consent.

\_\_\_\_\_\_ Occupational Therapy

\_\_\_\_\_\_ Speech and Language Therapy

\_\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/Guardian Signature Date

Previous OT/SLP Services  Yes  No

Original in Student Record  Copy to Student Support Services  Copy to Therapist